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ORIGINAL

MANAGEMENT OF THE END STAGE RENAL DISEASE PROGRAM

THIRTY-NINTH REPORT

BY THE

COMMITTEE ON GOVERNMENT OPERATIONS

together with

ADDITIONAL VIEWS

OCTOBER 1, 1982.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
Washington, D.C., October 1, 1982.

Hon. THOMAS P. O'NEILL, Jr.,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: By direction of the Committee on Government Operations, I submit herewith the committee's thirty-ninth report to the 97th Congress. The committee's report is based on a study made by its Intergovernmental Relations and Human Resources Subcommittee.

JACK BROOKS, *Chairman.*

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CONTENTS

	Page
I. Introduction	1
II. Background	2
III. Findings and conclusions	4
A. The HHS Office of Inspector General (OIG) has identified substantial overpayments which may reflect widespread waste and abuse in the ESRD program	4
B. HCFA has not managed the ESRD program in an efficient and economical manner	4
1. HCFA has maintained inadequate control over payments	4
a. HCFA has routinely granted facilities substantial exceptions to the established reimbursement rates without verifying the need for them	4
b. HCFA has overpaid many ESRD physicians by using the alternative reimbursement method	5
2. HCFA has failed to ascertain the actual cost of providing dialysis services	5
a. HCFA has never determined the economic impact of major changes in the delivery of renal dialysis services	5
b. HCFA's audit data for dialysis facilities are seriously deficient	6
(1) HCFA intermediary auditors did not conduct comprehensive audits for use in setting incentive reimbursement rates	6
(2) Related organization costs were inadequately audited for rate-setting purposes	7
c. HCFA does not have reliable data on the comparative costs of home and in-facility dialysis	7
d. HCFA has not assessed the dialysis costs of treating "atypical" patients	8
C. HCFA has not developed a dual reimbursement rate, as mandated by Congress	8
IV. Recommendations	9
A. Recommended legislative actions	9
B. Recommended management improvements	10
V. Waste and abuse in the ESRD program	10
VI. Deficiencies in the management of the ESRD program	13
A. HCFA has maintained inadequate control over payments	13
1. HCFA has routinely approved applications from facilities for higher reimbursement without determining the need for exceptions to the standard rate	13
2. HSFA has overpaid many ESRD physicians by using the alternative reimbursement method	14

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VI. Deficiencies in the management of the ESRD program—Continued
B. HCFA has failed to ascertain the actual cost of providing dialysis ---------- Page 16
1. HCFA has never determined the economic impact of major changes in the delivery of renal dialysis services ---------- 16
2. HCFA's audit data for dialysis facilities are seriously deficient ---------- 17
a. HCFA's intermediary auditors did not conduct comprehensive audits for use in setting incentive reimbursement rates ---------- 17
b. Related organization costs were inadequately audited for rate-setting purposes ---------- 19
3. HCFA does not have reliable data on the comparative costs of home and in-facility dialysis ---------- 23
4. HCFA has not assessed the dialysis costs of treating "atypical" patients ---------- 24
VII. Failure to develop a dual reimbursement rate ---------- 26

VIEWS

Additional views of Hon. Raymond J. McGrath ---------- 30

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97TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 97-918

MANAGEMENT OF THE END STAGE RENAL DISEASE PROGRAM

OCTOBER 1, 1982.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BROOKS, from the Committee on Government Operations, submitted the following

THIRTY-NINTH REPORT

together with

ADDITIONAL VIEWS

On September 28, 1982, the Committee on Government Operations approved and adopted a report entitled "Management of the End Stage Renal Disease Program." The chairman was directed to transmit a copy to the Speaker of the House.

I. INTRODUCTION

Under the rules of the House of Representatives, the Committee on Government Operations has responsibility for studying the operation of Government activities at all levels from the standpoint of economy and efficiency. The committee has assigned this responsibility as it relates to the Department of Health and Human Services (HHS) to the Intergovernmental Relations and Human Resources Subcommittee.

Since its enactment in 1972, the End Stage Renal Disease (ESRD) program has been highly successful in bringing life-sustaining technology to virtually all victims of chronic, life-threatening kidney disease, regardless of their financial means. The cost of the $1.5 billion ESRD program, however, has escalated far beyond anything Congress anticipated when it enacted this legislation.

It is against this background of rapid and continuing expenditure growth in the ESRD program that the subcommittee held hearings to evaluate how effectively, efficiently and economically it was being managed. Specifically, the hearings were designed to explore ways in which improved management practices might reduce program costs without compromising the quality and availability of services to the people in need.

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In addition to overall management concerns, the subcommittee's inquiry focused on procedures and methods used by program administrators to develop proposed reimbursement rates for renal dialysis services. Inasmuch as HHS had just recently proposed such rates, the subcommittee believed it was timely as well as important to determine how well the program has been achieving the twin objectives of minimizing Federal expenditures while assuring quality services for all who require them.

The Health Care Financing Administration (HCFA) is responsible for administering the ESRD program within HHS. On February 23 and 24, 1982,[1] the subcommittee held public hearings on HCFA's management of the ESRD program. Witnesses included the HCFA Administrator and the HHS Inspector General, whose office has closely monitored the ESRD program for approximately four years.

The subcommittee investigation included careful review of HCFA documents, including correspondence, internal memoranda, in-house computer data runs, program assessment studies, and draft program policy proposals. In addition, the subcommittee examined several classes of documents in the possession of the HHS Office of Inspector General, including correspondence, internal and inter-office memoranda, and audit workpapers and audit reports. The variety of documents studied permitted the subcommittee to evaluate the quality of ESRD program administration and, in particular, the degree to which HCFA implemented Office of Inspector General recommendations for program management improvements. The subcommittee also worked closely with and received a report from the General Accounting Office on the quality of the cost data HCFA used in developing proposed incentive reimbursement rates.

II. Background

Enacted in October 1972, the Social Security Amendments of 1972 (Public Law 92–603) extended Medicare coverage to virtually all victims of end stage renal disease. This essential program has been very costly. While fewer than one quarter of one percent of all Medicare Part B beneficiaries are served by the ESRD program, they account for almost 10 percent of all Part B expenditures. In 1974, the program served 18,000 patients at a cost of under $229 million. In 1981, however, the number served exceeded 68,000 and Federal expenditures increased to $1.5 billion. Under current policies and procedures, these costs are projected to reach $2.3 billion by 1984.

Outpatient maintenance dialysis can be provided in either a hospital-based or independent (often called "freestanding") setting. In 1981, there were 654 hospital-based and 466 independent outpatient dialysis facilities. While 95 percent of all hospital-based facilities are nonprofit, more than 75 percent of all independent facilities are private, for-profit entities. More than one-half of all independent facilities are members of chain organizations, the largest of which owns or operates approximately one-third of all independent facilities. Very few hospital-based facilities, by contrast, belong to chain organizations.

[1] Hearings before a Subcommittee of the Committee on Government Operations, House of Representatives, "The End Stage Renal Disease Program (Part 1—Management of the Program)," February 23 and 24, 1982, hereinafter referred to as Hearings.

Reimbursement rates for outpatient dialysis have remained unchanged since 1974. Both independent and hospital-based facilities have been subject to an "interim" national screen, or ceiling, of $138 or $150 per treatment,[2] depending on whether billings for routine physician supervisory and patient care services are included in the facilities' rates. Independent facilities are reimbursed their reasonable charge up to this screen, while hospital-based facilities are reimbursed their reasonable costs up to this screen. Medicare pays 80 percent of the rates established for both types of facilities.

Under existing rules, hospital-based facilities received an average of $159 per treatment in 1980, compared to $138 per treatment for independent facilities. Higher hospital rates reflect the large numbers of exceptions to the $138 national screen which hospital-based units have been granted. Facilities qualify for such exceptions if they can document that their costs justify them. Hospital-based facilities have far more frequently applied for and received exceptions to the rate limits than have independent dialysis units. In 1981, 350 or 54 percent of all hospital-based facilities were operating under rate exceptions, compared to only 29 or 6 percent of all independent facilities.

No reliable cost data were available when the current national facility charge ceiling of $138 or $150 per treatment was established in 1974. Although this screen has remained unchanged for more than eight years, it has not deterred entry into the dialysis services market. In particular, the number of independent facilities increased from 275 to 466, or 69.4 percent between 1978 and September 1981.

In June 1978, Congress enacted Public Law 95–292, the End Stage Renal Disease Amendments of 1978, which clarified that ESRD facility reimbursement rates are to be related to facilities' reasonable costs.[3] In addition to creating incentives for the promotion of lower cost home dialysis, these amendments required the Secretary to implement an incentive reimbursement system which will assure more efficient and effective delivery of dialysis services. However, implementation was delayed until audits could be conducted to establish the data base needed to set new incentive rates. While the Administration was still working on developing an incentive rate proposal, Congress passed Public Law 97–35, the Omnibus Budget Reconciliation Act of 1981, which amended the 1978 law by requiring the Secretary to establish dual or separately calculated prospective rates for hospital-based and independent dialysis facilities. Congress expressed a preference that these formulas be composite in nature; that is, they take into account the proportions of hospital-based and independent facility patients dialyzing at home and the relative costs of providing dialysis at home and in facilities. Based on cost data derived from 67 audits of hospital-based facilities and 38 audits of independent facilities, the Administration developed its Congressionally-mandated incentive reimbursement rate proposal, which was published in the February 12, 1982, Federal Register.

In that proposal, HCFA went the composite rate route by allowing an average of $132 for hospital-based on $128 for independent units.

[2] These screens include a $5 allowance for routine laboratory services which facilities can elect to have omitted from their per treatment rates. When routine laboratory services are not included in the facility charge, the national screen becomes either $133 or $145 per treatment.

[3] End Stage Renal Disease Program, Ways and Means Committee Report on H.R. 8423, July 29, 1977, p. 13.

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In the past, facilities received less for serving home patients than in-facility patients. For the first time, hospital-based and independent units will receive the same rates for home and in-facility patients. If, as is generally believed, home dialysis is less costly than in-facility dialysis, facilities are expected under this arrangement to send more of their patients home.

Based on Medicare hospital wage data, HCFA intends to apply a geographic labor index to its new rates.[4] Thus, rates will vary geographically, from a low of around $109 to a high of around $143 for independent facilities, and a low of $115 to a high of $147 for hospital-based dialysis facilities.

Independent facilities will fare considerably better under HCFA's proposed rates than hospital-based units. HCFA estimates that 46 percent of hospitals have costs which exceed these rates; only 28 percent of the independent facilities have costs exceeding these limits.[5]

III. Findings and Conclusions

A. The HHS Office of Inspector General (OIG) Has Identified Substantial Overpayments Which May Reflect Widespread Waste and Abuse in the ESRD Program

The five facility audits conducted by the Region II Office of the OIG since 1979 mark the first comprehensive audits ever performed of ESRD facilities. These audits revealed a number of ways in which ESRD funds have been improperly expended. Three of the five audited facilities were allowed substantial rate increases by significantly overstating their costs. Improper billing practices were discovered at all five facilities. Four facilities billed the Medicare program for duplicate services, and one facility charged the program for services not rendered at all. Since these problems were not suspected when the five facilities were selected for audit, they may well be prevalent throughout the entire ESRD program.

B. HCFA Has Not Managed the ESRD Program in an Efficient and Economical Manner

1. HCFA HAS MAINTAINED INADEQUATE CONTROL OVER PAYMENTS

a. HCFA has routinely granted facilities substantial exceptions to the established reimbursement rates without verifying the need for them

Despite the large number of facilities granted rate exceptions, HCFA's renal exceptions group has never in the program's ten-year history sought an audit of any faciilty applying for a rate increase. The Office of Inspector General has concluded that all three facilities with rate exceptions which it audited should not have received rate increases. The committee believes the Federal Government could have achieved substantial savings had HCFA routinely audited the costs reported by ESRD facilities in support of their rate exception applications.

[4] Conference Report to accompany P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981, expresses the expectation "that an area wage adjustment will be used in determining the reimbursement rate."

[5] Hearings, p. 151.

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b. HCFA has overpaid many ESRD physicians by using the alternative reimbursement method

Approximately 75 percent of all ESRD physicians are currently reimbursed through a capitation fee called the alternative reimbursement method (ARM). ARM payments cover all routine physician supervisory and patient care services. ARM fees for physicians treating patients in dialysis facilities are computed by multiplying the local Medicare prevailing charge for a medical specialist's brief followup office visit by a conversion factor of 20. This rate is based on the assumption that the complexity and frequency of physician supervisory and patient care services are worth about 20 office visits per month. According to an internal HCFA memorandum, no analytical data have ever been found to support this formula, which was established in 1974.[5a]

Analysts in HCFA's Bureau of Quality Control have concluded that ARM payments have been excessive. Bureau studies have found that some physicians never visit their clinics, while others do so only occasionally. The average number of physician visits, according to an internal memorandum from the bureau's director, appears to be "anywhere from three to five at most." [5b]

HCFA now proposes to reimburse all ESRD physicians under the ARM method, although at a reduced rate. HCFA has recommended lowering the ARM conversion factor from 20 to 12.4, with 12.4 representing the average number of dialysis sessions a patient has every month. In selecting this conversion factor, HCFA acknowledges that it assumes "a physician will see the patient at every dialysis session." [5c] As the Bureau of Quality Control found, however, the average number of times physicians visit their patients appears to be far less than the number of dialysis sessions a patient has every month. HCFA testified that it has neither conducted nor sponsored any studies that contradict the Bureau's findings. Nonetheless, HCFA disregarded those findings in assuming, for reimbursement purposes, that physicians visit patients at every dialysis session. The committee believes it would be wasteful and inappropriate to adopt a reimbursement method that compensates physicians for services they do not perform.

2. HCFA HAS FAILED TO ASCERTAIN THE ACTUAL COST OF PROVIDING DIALYSIS SERVICES

a. HCFA has never determined the economic impact of major changes in the delivery of renal dialysis services

Since 1974, ESRD facilities have been reimbursed under a fixed charge arrangement. Until recently, HCFA has not sought to modify that reimbursement level, despite the statement in the agency's rate proposal that the "provision of dialysis services has been characterized by increased efficiencies." It is widely believed that facilities have been able to lower their treatment costs substantially by shortening treatment time, reusing artificial hemodialyzers and, in some cases, increasing their treatment volume. At the same time, inflation may have exerted some countervailing upward pressure on dialysis costs.

In proposing new reimbursement rates, HCFA decided against

[5a] Hearings, p. 235.
[5b] Hearings, p. 252.
[5c] 47 Fed. Reg. 6567, Hearings p. 239.

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making any inflation adjustment in its 1977–1979 facility cost data, arguing that such adjustment is inappropriate. HCFA, however, has provided no objective evidence to substantiate its claim that efficiencies in the delivery of dialysis services have fully counteracted the inflationary pressures which plague other sectors of the medical care industry.

b. HCFA's audit data for dialysis facilities are seriously deficient

Following clarification in the ESRD Amendments of 1978 that ESRD facility reimbursement rates, including those for charge-based independent facilities, are to be related to reasonable costs, HCFA decided to undertake the first program audits ever performed of ESRD facility costs. However, the cost data from these audits are seriously deficient for several reasons.

(1) HCFA's intermediary auditors did not conduct comprehensive audits for use in setting incentive reimbursement rates

The data HCFA used to set new rates came from audits which are little more than superficial surveys. These were conducted by private insurance companies which act as fiscal intermediaries to process Medicare claims for the Federal Government. In a report to the subcommittee on these independent facility audits, the General Accounting Office noted that HCFA's audits failed to identify substantial amounts of excessive and unallowable costs. In a June 1981 internal document, HCFA officials admitted that their audit results were probably unreliable in that the auditors were given insufficient time to review records.

In fact, HCFA had disregarded the recommendation of the Office of Inspector General in early 1980 that HCFA allot the intermediary auditors sufficient time to perform reliable audits. In this connection, the Blue Cross Association refused to render an unqualified opinion on its auditors' work after learning how little time HCFA had allowed them to conduct these audits.

Since this was the first time in the ESRD program's history that facilities were to be audited for the purpose of setting nationwide, prospective reimbursement rates which would remain in effect for several years, the committee believes that HCFA should have obtained more reliable cost data.

In addition, HCFA did not require its hospital auditors to go on-site to verify costs reported by hospital-based facilities in its rate-setting audit sample. Instead, it instructed the auditors to perform only desk reviews to reconcile the costs shown on two different report forms. These desk reviews provide little assurance that the cost data which HCFA used to set prospective reimbursement rates are reliable, particularly since, as HCFA itself recognizes, hospitals reporting their Medicare expenses have had strong incentives to shift as many costs as possible to their outpatient dialysis departments. Only on-site audits can insure that the costs which hospitals report for these departments are properly allocated and reasonable. HCFA's failure to require on-site verification of reported costs seriously impairs the value of its hospital cost data.

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(2) Related organization costs were inadequately audited for rate-setting purposes

Increasing numbers of renal dialysis facilities purchase supplies and services, or lease facilities and equipment from financially-related organizations—that is, organizations which own or control them or which they own or control. Reasonable costs under Medicare regulations may not include facility, supply, or services costs incurred in transactions with related organizations which exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.[54]

After examining the independent facility audits used by HCFA to set incentive reimbursement rates, the General Accounting Office reported to the subcommittee that related organization costs were inadequately audited. For example, HCFA did not seek to identify unallowable costs reported for supply purchase transactions between financially related organizations. The majority of related organization costs reported by independent facilities involved supply purchases. HCFA did not undertake any audits to determine the actual costs incurred by related organizations selling dialysis supplies to facilities in its audit sample, or the costs at which such supplies could be obtained from nonrelated organizations.

HCFA also allotted its auditors insufficient time to audit the administrative overhead costs which the nation's largest dialysis chain allocated to its member facilities included in HCFA's audit sample. As a result, the auditors did not determine whether the chain's allocated home office costs were reasonable and related to patient care.

In some cases, what appeared to be related organization costs were not audited because the auditors were denied access to the related organization's records. For example, a large dialysis chain organization which provided the building, equipment, supplies, and administrative and clinical personnel for two of the independent facilities in HCFA's rate setting sample would not permit auditors to review their books to verify most of the costs reported by those two facilities. As a result, HCFA eventually decided to discard the two units from its original sample of 40 independent facilities.

c. HCFA does not have reliable data on the comparative costs of home and in-facility dialysis

Underlying Congressional efforts to promote home dialysis is the belief that home dialysis is a less costly treatment modality. The formulation of composite rates which largely reflect the relative costs of home and in-facility dialysis presumes the existence of accurate home dialysis data. Currently available data, however, do not permit a reliable assessment of the relative costs of home and in-facility dialysis. Audits conducted by the GAO show the costs of home dialysis to be considerably higher than those revealed by the audits HCFA used to set proposed composite rates.

The differences between the GAO and HCFA data could reflect differences in their audit methodologies. GAO made assumptions which could have overstated their home dialysis costs, while HCFA's assumptions could have understated theirs. At the same time, auditors of the

[54] 42 CFR § 405.427; Chapter 10 of HIM–15, Medicare Provider Reimbursement Manual.

Department of Health and Human Services who performed home dialysis audits for HCFA did not have sufficient time to question the appropriateness of the reported home dialysis costs which they reviewed.

Consequently, the accuracy of both the GAO and HCFA estimates of home dialysis costs is in doubt and the relative costs of home and in-facility dialysis remain unknown.

d. HCFA has not assessed the dialysis costs of treating "atypical" patients

HCFA has never attempted to determine whether outpatient dialysis costs are greater for sicker renal patients, even though for many years it granted numerous facilities generous rate exceptions on the grounds that they treated such patients. HCFA has proposed continuing the policy of permitting a facility an exception to the established rate if it can demonstrate that it has an "atypical patient mix." The committee believes that until HCFA has reliable information on the relationship between dialysis costs and patient mix, it cannot intelligently and responsibly implement such an exceptions policy.

Analysis of the impact of dialysis patient mix on facility costs is critical to an equitable dual rate reimbursement system, particularly as it relates to hospital-based facilities. HCFA's audit data showed that hospitals had median labor costs $20 per treatment higher than independent facilities. Hospitals traditionally defend their higher labor costs by claiming that they treat sicker patients who require more staff monitoring. Prior to the subcommittee's hearings, HCFA had conducted two studies—one in August 1980 and the other at the subcommittee's request in February 1982—which provided some evidence that hospital-based facility patients may be sicker than their independent facility counterparts. Despite these studies, HCFA maintained during the hearings that it had no data showing that hospital-based facility patients are any sicker than independent facility patients. Therefore, HCFA chose to disallow in its incentive rate proposal the $20 per treatment hospital labor cost differential disclosed by its audits. Another HCFA study completed almost three months after the subcommittee's hearings provides additional evidence that hospital-based facilities may treat sicker patients than independent dialysis clinics.

In issuing this latter study, HCFA did acknowledge the existence of "substantial evidence that hospital-based facilities have a more severe case mix than freestanding facilities." [5e] The extent to which HCFA allows hospital-based facilities higher rates for serving sicker patients should depend on the availability of reliable data correlating dialysis costs with differences in patient mix. HCFA, however, currently has no such data.

C. HCFA Has Not Developed a Dual Reimbursement Rate, as Mandated by Congress

In the Omnibus Budget Reconciliation Act of 1981, Congress mandated that the Secretary establish dual rates for hospital-based and independent facilities to reflect the "relative costs" of providing dialysis services in the two settings. HCFA has actually established a single

[5e] Letter on file in Subcommittee office.

rate with an arbitrary adjustment for hospitals, rather than two separately computed rates based on the costs of providing dialysis services in each type of facility.

In developing the single rate, HCFA used a methodology which combines hospital-based and independent facility data. Because HCFA's audits show that hospitals generally have substantially higher costs than independent units, this procedure produces higher rates for independent facilities than their own cost experience might justify. Since the central purpose of the new rates is to bring payments more closely into line with actual costs, and to prevent unnecessary Federal expenditures, this procedure could result in overpayments to independent facilities. As stated in a June 1981 HCFA internal document, combining hospital and independent facility cost data to set independent facility rates "would appear to provide a substantial windfall to many low-cost facilities." Moreover, if, as HCFA alleges, hospitals are considerably less efficient than independent facilities, the decision to base independent facility rates in part on hospital cost data is especially questionable.

In view of HCFA's failure to ascertain the actual cost of providing dialysis services, the committee wishes to emphasize that it is not passing judgment on the reasonableness of the dollar amounts independent facilities would receive under HCFA's incentive rate proposal. The committee, in fact, recognizes that the $128 average rate which HCFA proposes for independent facilities is $10 less than the current average independent facility rate. Whether independent facility rates are excessive also depends on what constitutes a fair profit for independent facilities, an issue which HCFA has never specifically addressed.

HCFA's decision to combine independent and hospital-based facility cost data also results in lower hospital-based facility rates. Despite the arbitrary upward adjustment HCFA has proposed for hospital reimbursement rates, hospitals would still receive an average of $3 per treatment less than their audited median costs. HCFA's proposed methodology, therefore, appears to penalize hospitals. The committee is aware, however, of the widely held opinion that a more restrictive hospital reimbursement policy will force needed and achievable efficiencies in hospitals' management. While the committee questions HCFA's procedures for setting hospital-based facility rates, it reserves judgment on the adequacy of any given set of rates until HCFA has produced reliable hospital-based facility cost data.

IV. Recommendations

A. Recommended Legislative Actions

The committee recommends that the Committee on Ways and Means amend the Social Security Act to improve the administration of the End Stage Renal Disease Program as follows:

1. Amend § 1881(b)(3) of the Social Security Act to require reimbursement on a fee-for-service basis for all routine patient care services provided by physicians in the ESRD program. Such routine patient care should be reimbursed on a per visit basis, with physicians permitted to bill for no more than one documented visit per patient dialysis session.

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2. Clarify that the authority of the Secretary to collect cost data from renal dialysis facilities [6] extends to the cost data of organizations related to such facilities by common ownership or control.

B. Recommended Management Improvements

The committee recommends that the Secretary of Health and Human Services take prompt action to correct the deficiencies noted in this report. The committee specifically recommends that:

1. HCFA be instructed to base dual ESRD facility reimbursement rates on the separate cost experience of hospital-based and independent dialysis facilities, as mandated by Section 2145 of Public Law 97–35.

2. Appropriate steps be taken to insure that fiscal intermediaries in the program audit or otherwise verify the costs reported by dialysis facilities in support of applications for rate exceptions. The committee strongly recommends that adequate funds be made available to intermediaries for this purpose.

3. HCFA immediately undertake new audits to remedy the cost data deficiencies disclosed in this report. Appropriate steps should be taken:

   a. To assure that sufficient time is allocated for full-scale, on-site audits of ESRD facilities.

   b. To assure that audits are made of related organizations where needed to compute the costs of audited facilities.

   c. To improve the data base needed to compute the comparative costs of home and in-facility dialysis, giving particular attention to the cost of paid aides required by home dialysis patients.

4. HCFA conduct or sponsor research to assess:

   a. The extent to which outpatient maintenance dialysis costs vary with differences in facility case mix.

   b. The impact of changes in the delivery of services on dialysis treatment costs.

   c. The impact of inflation on dialysis treatment costs.

V. Waste and Abuse in the ESRD Program

Not until 1979—about seven years after enactment of the ESRD program—was a comprehensive audit conducted of an ESRD facility. On February 16, 1979, the Region II Office of the HEW Inspector General began an audit of the Queens Artificial Kidney Center, an independent facility in Jackson Heights, New York. Except for four additional audits which the Office of Inspector General (OIG) has undertaken since that time, the subcommittee's hearing revealed that no other comprehensive audits of ESRD facilities have been performed.

In these five facility audits, the Region II auditors identified a number of ways in which ESRD funds have been improperly expended. Since the problems discovered in these audits were not suspected when the five facilities were selected for audit, HHS Inspector General Richard P. Kusserow testified that he believed it "likely" that such problems are prevalent throughout the country.[7]

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[6] 95th Congress, 2d Session, Senate Report No. 95–714, End Stage Renal Disease Program, page 11.

[7] Hearings, page 29.

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On January 15, 1982, the OIG issued its first final audit report on an ESRD facility.[8] The OIG found that the Queens Artificial Kidney Center improperly received $1,421,000 in Government payments for the period 1974 through 1980 because it inaccurately reported the costs of physician services.[9] The auditors recommended that the Government recover this amount, and reduce this proprietary facility's current $107.46 per treatment rate to $99.98 to prevent continuation of the physician overpayments.[10] The auditors also found duplicate charges for physician supervisory services of $150,732 and unsupported bad debt claims amounting to $37,783.[11]

The OIG concluded that the Queens facility had overstated its costs by $835,469 or $24.43 per treatment in 1977, and $696,200 or $20.08 per treatment in 1978.[12] Included among the excessive claims were unallowable profits on transactions with a financially related organization, including profits from leases of $308,707 and supply purchases of $181,671.[13]

However, the auditors' computations did not include any allowance for equity capital or administrative overhead allocated to the facility's parent company because no verifiable documentation supporting these allocations was available.[14] According to the audit report, officials of the parent company repeatedly denied the auditors' requests for such documentation.[15]

Larry K. Simmons, Acting Associate Director of the OIG's Office of Auditing, testified in the subcommittee hearings that Monroe Community Hospital in Rochester, New York, had charged the Federal Government $144,674 for 833 dialysis treatments which were never performed ("no-shows") in the period from December 1974 through May 1978.[16] The facility also billed Medicare $38,845 for 7,769 laboratory tests which was never performed.[17]

The OIG found that Monroe Community Hospital was paid $1,512,000, or an average of $43 per treatment in excess of its costs, from 1973–1977.[18] Since the ESRD program may reimburse hospital-based dialysis facilities only for the costs they actually incur in providing dialysis services, the OIG plans to recommend recovery of all excess Federal payments made to this facility.[19]

Raymond Yak, Assistant Regional Audit Director, in Region II of the OIG Audit Agency, testified that his office uncovered approximately 300 duplicate billings, totaling $40,000, by physicians serving patients at the Manhattan Kidney Center and the South Bronx Kidney Center, two independent facilities operated by the National Nephrology Foundation—which is a nonprofit dialysis services corporation.[20] Most ESRD physicians receive a monthly capitation payment for all routine supervisory and patient care services provided each patient.

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[8] Review of End Stage Renal Dialysis Rate Determination for Queens Artificial Kidney Center, Audit Control No. 02-22600.
[9] Hearings, page 78.
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Hearings, page 90.
[15] Hearings, page 42.
[16] Hearings, page 96.
[17] Ibid.
[18] Hearings, page 113.
[19] Draft Report on Audit of Claims Processing Operations under Part A of the Health for the Aged and Disabled: Rochester Hospital Service Corporation, Audit Control No. 02-12012, page 4. Report in subcommittee files.
[20] Hearings, page 122.

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Only one physician is entitled to receive this payment for each patient, since it is intended to cover all routine dialysis services which the patient requires. However, the auditors found that more than one physician often collected the capitation payment for a particular patient.

The OIG audit of the National Nephrology Foundation also disclosed substantial over-reporting of facility costs. For 1979, the auditors questioned $1,029,468, or 23 percent of the $4,406,704 in costs which the National Nephrology Foundation reported on its ESRD cost questionnaire.[21] The questionable costs included $347,608 in excessive administrative expenses; $264,774 in insufficiently documented bad debts; and $32,675 in conference expenses, $19,102 of which involved an international conference on hemodialyzer reuse sponsored by the National Nephrology Foundation. According to the auditors, the latter item had no direct relationship to patient care services.[22]

The auditors also questioned, as unrelated to direct patient care, an $111,780 National Nephrology Foundation contract with a prominent Massachusetts-based consulting firm for a research study on the reuse of artificial hemodialyzers.[23] A major purpose of this contract, the auditors discovered, was to prepare a National Nephrology Foundation proposal that would be submitted in response to the expected availability of Federal funding for such a study.[24] National Nephrology Foundation eventually succeeded in obtaining a $149,500 contract from the National Institutes of Health for a study of hemodialyzer reuse, for which the consulting firm served as a major subcontractor and co-principal investigator.[25] Had the costs of its contract with the consulting firm been financed through the requested Medicare rate increase, National Nephrology Foundation would have been reimbursed twice for the same work.[26]

The OIG also audited the costs reported by the Lydia E. Hall Hospital in Freeport, Long Island. The auditors identified approximately $300,000 in unallowable costs reported by this proprietry hospital for the fiscal year ending February 3, 1979.[27] The OIG plans to recommend in its final audit report an appropriate downward adjustment to the facility's reported costs.[28]

The Lydia E. Hall Dialysis facility was actually operated by an independent dialysis service chain—the International Health Company (IHC). IHC charged the hospital a management fee. IHC had allocated a portion of its parent company expenses to the facility as part of the management fee. In reviewing the documentation supporting this fee, the auditors found items such as aviation fuel for a charter airline owned by the president of IHC, theatre tickets, and vacations for IHC executives charged to administrative overhead.[29] None of these items were related to the provision of patient care at the Lydia E. Hall dialysis facility.[30]

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[21] Hearings, page 125.
[22] Ibid.
[23] Hearings, page 125.
[24] Letter from Inspector General Kusserow to the Subcommittee, May 9, 1982, Hearings, Appendix, page 305.
[25] Ibid.
[26] Ibid.
[27] Hearings, page 128.
[28] Ibid.
[29] Ibid.
[30] Ibid.

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The auditors also found that the facility had improperly marked up the costs of its supplies by $157,181, or 50 percent over cost.[31] IHC had formed a "paper" company to process supply orders. This company, which had no inventory, personnel, or warehouse, purchased supplies from an outside vendor and then billed the facilities for these supplies at 50 percent above what it paid for them.[32]

For the period March 1977 through January 1980, the auditors also identified Medicare overcharges totaling $85,934 for 559 duplicate billings for dialysis services at Lydia E. Hall Hospital.[33] During this period, both IHC and Lydia E. Hall Hospital had submitted claims for dialysis provided to patients who had been admitted as hospital patients. Correspondence found by the auditors indicated that the managements of Lydia E. Hall Hospital and IHC had known about this situation since 1979, and had even discussed the possibility of refunding the improper charges to the Medicare program.[34]

VI. Deficiencies in the Management of the ESRD Program

A. HCFA Has Maintained Inadequate Control Over Payments

1. HCFA HAS ROUTINELY APPROVED APPLICATIONS FROM FACILITIES FOR HIGHER REIMBURSEMENT WITHOUT DETERMINING THE NEED FOR EXCEPTIONS TO THE STANDARD RATE

Despite the large number of rate exceptions approved since the inception of the ESRD program, HCFA's renal exceptions group has never in the program's ten-year history requested an audit of any facility applying for a rate increase.[35] During 1979, for example, HCFA approved 221 of 235, or 94 percent, of the rate increase applications received from outpatient dialysis facilities.[36]

Inspector General Kusserow informed the subcommittee that substantial money savings could have been achieved had HCFA implemented his office's repeated recommendation that it audit the costs reported by ESRD facilities in support of rate exception applications.[37]

The work of the OIG's New York regional office underscores the significance for program costs of HCFA's consistent failure to audit applications for rate exceptions. Three of the five facilities audited in the New York area were operating under rate exceptions. In 1978, HCFA's renal exceptions group granted the Queens Artificial Kidney Center a rate increase from $107.46 to $116.22 per treatment, and, based on the new rate, approved a retroactive payment of $239,660.[38] The OIG determined that not only was the Queens Center not entitled to a rate increase, but that it actually owed the Government $1,421,200 because of inaccurate reporting of the costs of physician services from 1974 through 1980.

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[31] Hearings, page 134.
[32] Ibid.
[33] Review of End Stage Renal Dialysis Rate Determination for Lydia E. Hall Satellite Dialysis Facility under Title XVIII of the Social Security Act Administered by Health Care Financing Administration. Draft Audit Report, Audit Control No. 02-22602, pages 17-18. Report in subcommittee files.
[34] Ibid, page 17.
[35] Hearings, page 79.
[36] End Stage Renal Disease Second Report to Congress Fiscal Year 1980, page 49.
[37] Hearings, page 90.
[38] Hearings, page 78.

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Monroe Community Hospital in Rochester, New York, was granted an exception to the national rate screen amounting to $172 per treatment, although the OIG auditors determined its costs to be $127 per treatment.[39] Since hospital-based facilities are reimbursed for their costs, Monroe should have received less, not more than the $138 national rate screen.

HCFA also approved a substantial rate increase to $163 per treatment for the Lydia E. Hall Hospital in Freeport, New York. The OIG found the facility's per treatment cost to be approximately $106, or $56 less than its increased rate.[40]

One of the two facilities operated by the National Nephrology Foundation—Manhattan Kidney Center—had sought a rate exception which was pending at the time the OIG's New York office decided to audit it. Because the auditors questioned almost one-fourth of the costs reported by the Manhattan Kidney Center, Inspector General Kusserow testified that he would recommend denial of the facility's pending rate exception application.[41]

A well-administered, tightly controlled exceptions policy is absolutely critical to the success of any incentive rate system HCFA seeks to implement. This objective would be seriously compromised by continued laxity in the management of HCFA's exceptions policy.

2. HCFA HAS OVERPAID MANY ESRD PHYSICIANS BY USING THE ALTERNATIVE REIMBURSEMENT METHOD

The ESRD facility reimbursement rate does not include physician services payments. Physicians are usually reimbursed for routine outpatient maintenance dialysis services on a monthly capitation basis under what is called the alternative reimbursement method, or ARM.

Currently the ARM payment for in-facility services is computed by multiplying the charge for a routine followup office visit by a conversion factor of 20, based on the assumption that the complexity and frequency of physician supervisory and patient care services are worth about 20 office visits per month.[42] ARM payments currently vary nationally between $180 and $260 per patient per month, with $220 the national average.

While HCFA has been paying these physician reimbursement rates, it never obtained empirical evidence to support the rationale for calculating the ARM payment levels. The current ARM method, as one HCFA internal memorandum conceded, was "established absent analytical data to support it and no such data has been found since."[43]

Two studies conducted by HCFA's Bureau of Quality Control have concluded, in fact, that ARM payments have been excessive. In a Validation Report on Survey of Three Freestanding End Stage Renal Disease Facilities issued in September 1980, the Bureau of Quality Control stated, based on patient interviews and medical record reviews, that "the majority of patients receive few direct physician services except a monthly examination." The report also determined that "there is no need for a physician to visit patient each treatment," especially for "patients in stable condition."[44] The report concluded:

[39] Hearings, page 113.
[40] Hearings, page 127.
[41] Hearings, page 124.
[42] Intermediary Letter 74–20, June 1974.
[43] Hearings, page 235.
[44] Hearings, page 239.

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"Based upon our review, the current method of reimbursement pays for services far in excess of those actually provided." [45]

In 1981, the Bureau of Quality Control drafted a second report on ESRD physician services, a national survey which found that some physicians collect ARM payments even though they never visit their clinics. Others made visits only once every two weeks. In the facilities reviewed in one HHS region, physicians averaged only 26 to 39 minutes per patient per month. Documented services in two facilities in that region averaged from 1.12 to 1.56 visits per patient per month. Other regions were little different. The Bureau of Quality Control again observed: "It would seem that the typically stabilized patient on dialysis has little need for physician services during treatment." [46] The report concluded: "Our reviews have demonstrated that the formula in use is producing physician reimbursement which is not reasonable based upon the services provided." [47]

Recognizing that ARM payment levels for in-facility services are excessive, HCFA now proposes reducing them. HCFA has proposed cutting the ARM payment from the national average of $220 per patient per month to $184 per patient per month, primarily by reducing the conversion factor from 20 to 12.4, with 12.4 designed to reflect the average number of dialysis sessions a patient has every month.[48]

In recommending a conversion factor which reflects the average number of dialysis treatments a patient has every month, HCFA expressly assumes that "a physician will see the patient at every dialysis session." [49] In this connection, Dr. Carolyne Davis testified that while some physicians do not see their patients often, "[s]ome physicians see their patients absolutely every time they visit the facility." [50] While this may be true, the average number of times physicians visit their patients appears to be far less than the number of dialysis sessions a patient has every month. A January 14, 1981, memorandum from Don Nicholson, director of the Office of Program Validation in HCFA's Bureau of Quality Control, states that if services actually rendered were to be the measurement for physician reimbursement, the conversion factor used to set a monthly capitation payment would "be anywhere from three to five at most," far less than the average number of monthly patient dialysis sessions.[51]

Martin Kappert testified that HCFA had done no studies which contradicted that findings of its Bureau of Quality Control.[52] Since HCFA had no other information on the scope of ESRD physician services, the committee believes the agency should have used the Bureau's findings in proposing revisions in physician reimbursement policies.

HCFA's proposed physician reimbursement policy is designed, Dr. Carolyne Davis testified, not to "penalize" physicians who see their dialysis patients often.[53] The committee believes, however, that it would be wasteful and inappropriate to adopt a reimbursement method that compensates physicians for services they do not perform.

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[45] Ibid.
[46] Hearings, page 246.
[47] Ibid.
[48] 47 Federal Register 6567.
[49] 47 Federal Register 6567, Hearings, page 239.
[50] Hearings, page 252.
[51] Ibid.
[52] Hearings, page 249.
[53] Hearings, page 252.

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Dr. Davis sought to minimize the significance of the Bureau of Quality Control findings by emphasizing that "there are a number of services that the individual physician provides that are not one-on-one," such as telephone consultations and supervision of the nursing staff.[54] HCFA acknowledges, however, that it currently lacks any data which documents the extent to which ESRD physicians engage in services other than hands-on care. Such services, Dr. Davis testified, "are not yet measurable." [55] More important, HCFA's stated assumption in computing a conversion factor for the ARM is that "a physician will see the patient during every dialysis session."

Furthermore, HCFA officials, including Martin Kappert, a HCFA witness at the subcommittee's February 24 hearing, have voiced strong reservations about reimbursing physicians for time spent away from the patients for whom they collect monthly capitation payments. In a memorandum dated June 15, 1981, Mr. Kappert, formerly the director of the Bureau of Quality Control, wrote:

> The fact that three regions found physicians in five out of nine facilities reviewed were treating private patients for other than renal problems at the facility site during periods when dialysis was being performed demonstrates that ARM physicians are not necessarily on "standby" as has been alleged.[56]

In a January 14, 1981, memorandum, Donald Nicholson, director of the Bureau of Quality Control's Office of Program Validation, similarly noted that ARM physicians may be earning money seeing private patients while they are collecting for alleged supervisory care and questioned "whether such physicians typically are 'on call' only for dialysis patients and should therefore be compensated for this time." [57]

B. HCFA Has Failed To Ascertain the Actual Cost of Providing Dialysis

1. HCFA HAS NEVER DETERMINED THE ECONOMIC IMPACT OF MAJOR CHANGES IN THE DELIVERY OF RENAL DIALYSIS SERVICES

Virtually since the inception of the program, most ESRD facilities have been reimbursed up to a fixed screen or maximum amount of $138 or $150 per treatment, depending on whether they elect to include billings for routine physician supervisory and patient care services in their rates. This has been especially true for independent facilities, only six percent of which were operating under exceptions to their established screens in 1981.

Over the several years that the national ESRD facility screen has remained fixed, many changes have occurred in the delivery of renal dialysis services. Perhaps prompted in part by the economic incentives imposed by a fixed prospective per treatment rate, the renal dialysis industry has discovered several ways to cut costs. Most notable among them is the dramatic reduction in dialysis treatment time, from 24 hours a week in the 1960's to 10 to 12 hours at present.[58] This develop-

[54] Hearings, page 249.
[55] Hearings, page 252.
[56] Hearings, p. 267.
[57] Hearings, p. 264.
[58] Hearings before a Subcommittee of the Committee on Government Operations, House of Representatives, "The End Stage Renal Disease Program (Part 2—Treatment Standards and Methods)," April 28, 1982, p. 28.

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ment, to some extent, may reflect the availability of larger surface dialyzers, as well as a shift in nephrology practice philosophy. In addition, multiple use of the most expensive dialysis supply item—the artificial kidney or hemodialyzer—has become increasingly popular. A study by the Renal Physicians Association showed that in 1981, 27.5 percent of patients in surveyed facilities were treated with reused dialyzers, compared to only 16.5 percent of patients in 1978.[59] Through increased treatment volume, some facilities may also have achieved economies of scale which allow them to decrease their per treatment costs.[60]

HCFA recognizes, as it states in its rate proposal, that "the provision of dialysis services has been characterized by increased efficiencies."[61] At the same time, it is reasonable to assume that inflation has affected many dialysis facility costs. HCFA believes, however, that efficiencies achieved by the industry have wholly offset the effects of inflation. Thus, in proposing new reimbursement rates, HCFA has decided against making any inflation adjustment in its 1977–1979 facility cost data, arguing that no such adjustment is appropriate.[62]

HCFA, however, has never conducted or sponsored any research on the effects of inflation on dialysis treatment costs. It has improperly inferred from the continued entry of new dialysis facilities—particularly independent facilities—into the market, that inflation has not affected industry costs.[63] Because the delivery of dialysis services remains sufficiently profitable for the market entry of new facilities does not mean treatment costs are not affected by inflation. Relying on cost data that are three to five years old, HCFA has neglected to produce the kind and quality of market data needed to determine reimbursement rates that appropriately minimize Federal expenditures while recognizing the legitimate costs and capital needs of facilities.

2. HCFA'S AUDIT DATA FOR DIALYSIS FACILITIES ARE SERIOUSLY DEFICIENT

a. HCFA's intermediary auditors did not conduct comprehensive audits for use in setting incentive reimbursement rates

For the first time in the ten-year history of the ESRD program, HCFA has proposed reimbursement rates which are based on the results of ESRD facility cost audits. The audit sample HCFA is using to set new rates includes 38 independent and 67 hospital-based dialysis facilities. In response to HCFA's announced plans to allow its intermediary auditors 80 hours for hospital-based facility audits and 150 hours for independent facility audits, the HHS Office of Inspector General informed HCFA in January 1980 that little more than "survey type reviews" of these facilities could be accomplished in the short time HCFA allotted for facility cost reviews.[64] In this connection, the Blue Cross Association refused to render an unqualified opinion on the work of its auditors after learning how little time HCFA had allotted for these audits.[65]

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[59] "Report of National Workshop on Reuse of Consumables in Hemodialysis," Contemporary Dialysis, July 1982, p. 30.
[60] Hearings, p. 91.
[61] 47 Federal Register 6565.
[62] Ibid.
[63] Ibid.
[64] Hearings, p. 134.
[65] Hearings, p. 138.

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The OIG recommended that HCFA make sufficient money available for the conduct of comprehensive audits using the intermediaries' in-house staffs, and that the intermediaries be given additional funds for contracting out to others to pick up otherwise neglected portions of the normal audit workload.[66] Inspector General Kusserow testified that HCFA ignored this advice, which resulted in the "survey type reviews" his office had cautioned HCFA against.[67]

A draft notice of proposed rulemaking which circulated within HCFA in June of 1981 stated that:

> The audit results themselves are likely to be biased high, since our auditors had little time to review records, and therefore, not only accepted each facility's records as they were, but probably were not able to identify all excludable costs.[68]

Since this audit effort marks the first time in the program's history that facility cost audits were to be performed to set nationwide prospective rates which would remain in effect for several years, the committee believes HCFA was remiss in not obtaining more reliable cost data.

Despite the documentation quoted above, HCFA Administrator Carolyne Davis testified that the full-scale audits which the OIG had recommended would not only have been costly, but also "would not have made a significant difference in the rate itself. Maybe a $1 or $2 [per treatment] factor would have been at most." [69]

A February 11, 1982, letter report from the General Accounting Office to the subcommittee [70] refutes Dr. Davis' assertion that more comprehensive audits would have at most yielded a $1 or $2 difference in per treatment costs. In its examination of 12 of the 38 audits of independent facilities HCFA used to set new rates, GAO indicated that at a minimum HCFA's median facility treatment cost was overstated by an average of approximately $5.50 per treatment.[71] In some cases, GAO stated that HCFA's rate setting audits overstated costs by at least $10 per treatment.[72]

HCFA's procedures also prevented adequate audits of hospital-based facility costs. OIG witnesses questioned the soundness of HCFA's hospital audit procedures. Larry K. Simmons testified that HCFA did not require its hospital auditors to go on-site to verify the costs reported by hospitals in its audit sample.[73] Instead, it required those auditors to perform only desk reviews to reconcile the costs listed on two different reporting forms—the standard Medicare hospital cost report (HCFA Form 2552) and the ESRD cost questionnaire (HCFA Form 9734).[74] These desk reviews enabled HCFA to disallow only three percent of the costs reported by the hospitals in its audit sample. Inspector General Kusserow testified that on-site auditing of two New York hospital-based dialysis units—Lydia E. Hall Hospital and Monroe Community Hospital—revealed adjustments far in excess of three

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[66] Ibid.
[67] Ibid.
[68] Hearings, p. 217.
[69] Ibid.
[70] Information on Selected Medicare Independent Dialysis Facility Audits, HRD–82–42, February 22, 1982.
[71] Hearings, p. 225.
[72] Ibid.
[73] Hearings, p. 138.
[74] Ibid.

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percent of reported costs.[75] Costs were adjusted downward 35 percent in the former and 26 percent in the latter. Since hospitals are reimbursed for only their reasonable costs, more intensive auditing, Inspector General Kusserow added, could also have meant additional Federal recoveries of past hospital overpayments.[76]

Robert Streimer of HCFA's Bureau of Program Policy testified that only a "minimal amount of time" was needed for hospital audits since hospitals are periodically audited by the fiscal intermediaries as part of the normal end-of-the-year Medicare cost report settlement process.[77] HCFA acknowledged, however, that almost all such hospital audits are desk reviews.

These desk reviews would generally seek to determine whether a hospital's costs are properly allocated to its renal department. They would not necessarily seek to verify the propriety and allowability of specific costs attributed on the hospital's Medicare cost report to its renal unit. Mr. Streimer, in fact, later testified before the House Ways and Means Oversight Subcommittee that hospitals reporting their Medicare costs often overload their dialysis units with improperly allocated costs:

> Mr. STREIMER. * * * I think it is very important to go back to a comment that was made this morning, where several of the hospital representatives noted that it has actually historically been in the hospital's interest to shift as much cost as possible to the outpatient dialysis department, because the Federal Government reimbursed more money in that department.
>
> We pay on average 90 percent of the cost in the dialysis department, whereas in any other department in the hospital we pay on average 30 percent. So for instance, the George Washington Hospital has $12 per treatment for their educational programs in the hospital. Other hospitals have large amounts of laundry and linen cost and supply costs in the dialysis department, even though the dialysis unit may not use those supplies, primarily because it has been favorable to the hospital's overall reimbursement to do their accounting in that fashion.[78]

Short of required on-site auditing, the Federal Government has no assurance that it can identify the costs which HCFA itself acknowledges are frequently allocated by hospitals to their outpatient dialysis departments.

Furthermore, hospitals are not necessarily desk reviewed every year. In fact, a table which HCFA submitted for the subcommittee hearing record shows that 14 of the 67 hospitals in its audit sample had not been recently desk reviewed prior to their selection for the rate-setting project.[79]

b. Related organization costs were inadequately audited for rate-setting purposes

Increasing numbers of renal dialysis facilities buy and lease from, or are managed by, related organizations; that is, from organizations

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[75] Hearings, pp. 138, 139.
[76] Hearings, p. 139.
[77] Hearings, p. 226.
[78] Hearing before a Subcommittee of the Committee on Ways and Means, House of Representatives. "Proposed Regulations Governing Reimbursement under the Medicare End-Stage Renal Disease Program," April 22, 1982, transcript, pp. 176–177.
[79] Hearings, pages 228–231.

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which own or control them or which they own or control. Reasonable costs under Medicare may not include facility, supply, or service costs which exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.[80] Related organization transactions involving supply purchases and management and administrative services contracts, GAO estimates, usually accounted for more than 40 percent of the costs reported by independent dialysis facilities in HCFA's rate-setting sample whose audits it reviewed.[81]

The amount of unallowable costs reported by facilities engaged in transactions with financially related organizations can be very sizeable, as the audit work of OIG's Region II personnel illustrates. The OIG audit of the Queens Artificial Kidney Center found $490,378 in unallowable related organization charges, including $308,707 for lease-back arrangements with the parent company and $181,670 for supply purchase from a supply company subsidiary of the parent company.[82] The OIG also found the Lydia E. Hall Hospital included in its reported costs $157,181 in excess costs related to supply purchases from its own supply companies.[83] Related organization problems are not confined to proprietary institutions. The Monroe Community Hospital dialysis clinic served as an extension of the University of Rochester School of Medicine. The OIG auditors have challenged $380,479 of the administrative overhead costs which the University charged to the facility from 1973 to 1977. Since the University and the facility did not bargain at arm's length, the OIG auditors concluded that the Government should not be bound by the excessive overhead fee which the University sought to charge the Monroe dialysis unit.[84]

In an April 3, 1979, letter to then HCFA Administrator Leonard Schaeffer, Robert E. Iffert, assistant director of GAO's Human Resources Division, discussed the results of a GAO survey of independent facility cost reporting practices in light of the requirement in Public Law 95–292 that the Secretary prescribe methods and procedures for determining dialysis facility costs in order to establish incentive rates. Three of the five facilities which GAO visited "purchased or leased supplies and equipment from related organizations at prices that included markups which in at least two cases appeared material for rate setting purposes." The GAO letter urged that Medicare related organization cost principles "receive close scrutiny for rates established in subsequent years." [85]

The ESRD rate-setting process did not give related organization costs the kind of "close scrutiny" GAO had earlier urged. In its February 11, 1982, report to the subcommittee, GAO stated that the intermediary auditors who performed the audits HCFA used to set new rates may not have detected substantial amounts of excessive costs reported by facilities which purchased supplies and/or services from financially related organizations. GAO noted that $6 million of the $15.4 million in reported independent facility costs which it reviewed involved transactions with related organizations. GAO's review found that "substantial portions of costs were included in the cost reports

[80] 42 CFR § 405.427, Chapter 10 of HIM–15, Medicare Provider Reimbursement Manual.
[81] Hearings, page 219.
[82] Hearings, pages 40, 41, 78.
[83] Hearings, page 134.
[84] Draft report on audit of claims processing operations under Part A of the Health for the Aged and Disabled: Rochester Hospital Service Corporation, Audit Control Number 02–12012, pages 14–16, 18. Report in subcommittee files.
[85] Letter on file in Subcommittee office.

without adequate assurance of compliance with Medicare regulations concerning related organizations." [86]

Included among the costs which GAO found to be insufficiently audited were "home office and regional office costs reported by chain facilities." [87] The committee believes that HCFA did not allow sufficient time to audit the administrative overhead costs which the nation's largest dialysis chain allocated to its twelve member facilities originally included in HCFA's audit sample of 40 independent facilities. These twelve facilities accounted for almost 52 percent of the treatments furnished by those 40 facilities.

In a February 3, 1982, letter to the subcommittee [88] the Blue Cross auditor responsible for the parent company audit estimated that a comprehensive home office audit would take 2,500 hours. He further stated that HCFA did not allow his office sufficient lead time to conduct a comprehensive parent company audit and refused his office's request for an extension of the July 31, 1980, audit deadline. Consequently, only about 400 hours, less than one-sixth of the time estimated for a quality audit, was spent reviewing the books of the parent company. In a July 23, 1980, letter informing HCFA that they were able to conduct only a "limited examination" of the parent company's reported expenses, the Blue Cross auditors wrote:

> Because the scope of our examination was not sufficient to constitute an examination made in accordance with generally accepted auditing standards, we do not express an opinion on the allocation schedules. We were unable to fully substantiate certain costs due to the time constraints in meeting the completion of the project by July 31, 1980.[89]

One Blue Cross official told GAO auditors that "no effort had been made to determine if the home office costs were reasonable or if the costs were related to patient care. . . . For most of the $10 million home office expenses the auditor simply verified that the amounts reported agreed with the amounts shown in the parent company's general ledger." [90] The intermediary auditors, for example, made no attempt to determine whether the $5.3 million which the chain reported paying physicians and physician groups operating its facilities as a home office expense was reasonable.[91] The payments were made for facility administration and/or profit sharing agreements and were generally based on facility profits. GAO concluded that this Blue Cross home office expense audit "cannot reasonably be used to determine the cost of dialysis treatments." [92]

Approximately 60 percent of the related organization costs which the GAO identified in its review of HCFA's independent facility audits were for dialysis supplies.[93] In its report to the subcommittee,

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[86] Hearings, page 225.
[87] Hearings, page 220.
[88] Letter on file in Subcommittee office.
[89] Letter on file in Subcommittee office.
[90] Statement of Michael Zimmerman, Associate Director, GAO Human Resources Division before the Senate Finance Health Subcommittee. Hearing before the Subcommittee on Health of the Committee on Finance, Senate. "Proposed Prospective Reimbursement Rates for the End-Stage Renal Disease Program," March 15, 1982, page 19.
[91] Ibid., page 24.
[92] Ibid., page 19.
[93] Hearings, page 219.

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GAO noted that "none of the audits determined the actual costs to the related organizations selling dialysis supplies or the costs at which the supplies could be obtained from nonrelated organizations." [94]

The nation's largest proprietary dialysis chain, for example, purchases its supplies from a wholly-owned supply company. The Office of Inspector General found that the Queens Artificial Kidney Center—a member of this chain—had reported $181,671 in unallowable profits on purchases of supplies from this company. In 1980, HCFA informed the parent company that it intended to audit its supply company subsidiary as part of its rate-setting effort. This audit was to have provided information on the costs of the supplies which the chain's facilities in the audit sample purchased from this subsidiary.

In the face of objections from the parent company,[95] HCFA abandoned its original decision to audit the supply company's books and instead directed some of its Blue Cross auditors to conduct a brief verification of a sales summary provided by the parent company. The auditors did not go on-site to the supplier's headquarters.

Robert Streimer of HCFA's Bureau of Program Policy testified that he thought HCFA's decision to forego an audit was justified, since a comparison of the supplier's charges to those of other suppliers showed "no substantial differences." [96] As a recent HCFA contract study performed by the Orkand Corporation shows, however, suppliers often offer discounts to facilities which purchase supplies in bulk.[97] Whether a supplier's charges to related facilities are truly comparable to those paid by unrelated facilities depends on the discounts the supplier may offer. This information can be obtained most reliably by auditing the supplier's books. In abandoning its decision to audit the supplier, HCFA merely relied on the parent company's representation in an April 3, 1981, letter that "to the best of our knowledge and belief no such discounts, rebates or other price concessions were granted" by the supply company to its customers.[98] It did nothing to verify the truthfulness of this representation.

HCFA has not always been allowed to audit related organization costs. HCFA discarded from its audit sample two of the twelve facilities affiliated with the nation's largest dialysis service chain organization because its intermediary auditors were denied access to records at the organization's home office which supported the costs reported by these two facilities. Although the chain organization furnished the facility, equipment, supplies, and administrative and clinical personnel for these two units,[99] it nonetheless claimed that it was not "related" to the facilities and therefore did not have to make its accounting records available to the auditors.[100] Since the records supporting virtually all of the direct costs reported by the facility were in the possession of the managing chain organization rather than the two facilities, almost $2.4 million of the costs which those facilities re-

[94] Hearings, page 220.
[95] May 16, 1980, letter from parent company to Earl M. Collier, Jr., Deputy Administrator, HCFA. Letter on file in Subcommittee office.
[96] Hearings, page 225.
[97] The Orkand Corporation, *Draft Market Study of Selected ESRD Equipment and Supplies*, HCFA Contract No. 500-79-0054, pages V13-15.
[98] Letter on file in Subcommittee office.
[99] Audit workpapers for the two facilities are on file in Subcommittee office.
[100] April 19, 1981, letter from Blue Cross/Blue Shield to John Jansak, Director, Office of Standards and Performance Evaluation, HCFA, Bureau of Program Operations. Letter on file in Subcommittee office.

ported could not be verified.[101] Rather than challenge the right of the chain organization to keep these records from its program auditors, HCFA elected to eliminate the two facilities from its carefully selected audit sample.

3. HCFA DOES NOT HAVE RELIABLE DATA ON THE COMPARATIVE COSTS OF HOME AND IN-FACILITY DIALYSIS

Underlying Congressional efforts in P.L. 95–292 and P.L. 97–35 to promote home dialysis is the assumption that home dialysis represents a less expensive modality of treatment. Data obtained by HCFA from home dialysis audits performed for it by the OIG show a composite median cost for the major forms of home dialysis [102] of $97 considerably less than the $108 and $135 composite median costs HCFA has computed for in-center dialysis provided by independent and hospital-based units respectively.

However, home dialysis data developed by the GAO suggest that the costs of home dialysis may be considerably higher. Based on a sample of 308 patients, GAO calculated a median audited home hemodialysis cost of about $105, some $18 higher than the $87 home hemodialysis median which the OIG's home audits show.[103] This figure does not include the cost of home aides which Robert Streimer of HCFA testified might be "in the neighborhood of $25 to $30." [104] HCFA currently lacks data showing the extent to which patients would require paid aides before opting for home dialysis.[105]

The differences between the GAO and the OIG data used by HCFA could reflect differences in audit methodology. GAO examined home dialysis costs on a per patient basis. Its audits included patients who directly billed Medicare for supplies and equipment as well as those who were provided supplies and equipment through their servicing facilities. OIG auditors, by contrast, reviewed home costs on a per facility basis. Their data only relate to patients who obtained their supplies through a facility. Since, as GAO acknowledges, home patients receiving their supplies from a facility "should obtain them at a lower cost because of the advantages of volume purchasing by facilities and hospitals," [106] HCFA's data could be of greater predictive value because HCFA's proposed composite rate system envisions more such volume purchasing. As GAO notes:

> Because HCFA proposes to use a combination rate covering both home and in facility patients, it probably is more appropriate to use a sample like HCFA's because under the proposed rates most home patients are expected to obtain their supplies through the facility.[107]

At the same time, HCFA made some questionable assumptions which could have understated the costs of home dialysis. For example it assumed that home patients dialyzed exclusively at home without any in-facility treatments during the year, an assumption which could

[101] October 3, 1980, Notes of Exit Conference concerning audits of the two facilities. On file in Subcommittee office.
[102] These include home hemodialysis, continuous ambulatory peritoneal dialysis (CAPD) and intermittent peritoneal dialysis (IPD).
[103] Hearings, page 233.
[104] Ibid.
[105] Hearings, pages 233, 234.
[106] Op Cit., Michael Zimmerman, page 25.
[107] Ibid.

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overstate the annual number of home treatments and, consequently, understate the average cost per home treatment.[108]

On the other hand, because the OIG home dialysis audits were very cursory, they may not have identified all excessive and unallowable costs. In its February 12, 1982, rate proposal, HCFA notes:

> The HHS audit agency [OIG] visited each of these facilities and reviewed its costs. Because of limited time, the audit agency did not attempt to make adjustments as to the reasonableness of these costs, but simply accepted the costs as reported.[109]

Currently available data on home dialysis costs do not warrant any definitive conclusion concerning the comparative costs of home and in-facility dialysis.

4. HCFA HAS NOT ASSESSED THE DIALYSIS COSTS OF TREATING "ATYPICAL" PATIENTS

During the many years that it granted numerous facilities rate exceptions on the grounds that they treated sicker patients, HCFA never attempted to assess whether, and to what extent, outpatient maintenance dialysis costs vary with differences in patient mix. HCFA, for example, has never conducted any studies to compare the costs of treating renal patients with differing types of medical complications, such as diabetes, hypertension, or cardiovascular disease.[110] Robert Streimer of HCFA's Bureau of Program Policy, in fact, acknowledged before the subcommittee that " we do not have any evidence that it costs any more to provide routine dialysis to sicker patients.[111] In a similar vein, Dr. Carolyne K. Davis wrote the subcommittee in a June 8, 1981, letter that her agency is "unable to detect any evidence that differential case mix has an impact on the cost of dialysis." [112] The committee believes that HCFA's failure to obtain information relating dialysis costs to variations in patient mix is indefensible in view of its longstanding practice of granting higher rates on the grounds that they served sicker renal patients.

HCFA has proposed continuing the policy of permitting a facility an exception to its established rate if it can demonstrate that it has an "atypical patient mix," particularly if it treats unusually sick patients.[113] Without baseline data identifying variations in patient mix with differential costs of outpatient dialysis, HCFA will not know how much to allow facilities seeking rate exceptions for providing outpatient dialysis to exceptionally sick renal patients. The committee believes that until HCFA has such baseline data, it cannot intelligently and responsibly implement such an exceptions policy.

Rather than define the "atypical patient mix" exception HCFA expects to learn what that exception means over time. Mr. Streimer informed the subcommittee:

> We expect that as we get exceptions we will learn more about typical case mix and as we get better data as these new

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[108] Ibid., page 25.
[109] 47 Federal Register 6563.
[110] Hearings, p. 233.
[111] Hearings, p. 232.
[112] Letter on file in subcommittee office.
[113] Hearings, p. 232.

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> cost reports begin flowing into the system, we will then be in a much better position to make cost judgments relative to specific areas of cost that tend to move possibly with different case mixes.[114]

Until HCFA is able to define the atypically costly patient, facilities will not know whether they qualify for a rate increase based on the "atypical patient mix" exception. Only when objective standards are established for this purpose can facilities claiming an "atypical patient mix" be assured of protection against arbitrary agency decisions on their rate exception applications.

HCFA's failure to acquire reliable information on the relationship between dialysis patient mix and facility costs also has crippled its ability to assure an equitable dual rate reimbursement system, particularly as it relates to hospital-based facilities. HCFA's audits showed that hospitals had median labor costs $20 per treatment higher than independent facilities. Hospitals traditionally defend their higher labor costs by claiming that they treat sicker patients who require more staff monitoring.

In its rate proposal, HCFA disallowed the hospital labor cost differential of $20 per treatment which its audits had found for the following reasons:

> Some hospital units claim that one reason they have higher labor costs than independent facilities is that they treat more patients with multiple conditions or other complications (including the elderly and pediatric patients) that require more highly trained staff and more staff per patient. The data presently available to us through our medical information system do not support this claim. We have examined age, sex, race and utilization rate (discharges and days of care) differences between hospital-based and freestanding facilities. The differences were small and did not approach statistical significance. We conclude, therefore, that with respect to these measures of patient need, there is no great difference between hospital based and independent facilities.[115]

HCFA, however, did have evidence that hospital-based patients may be sicker and costlier to treat than independent facility patients. Based on ESRD Medical Information System data, an August 18, 1980, internal memorandum from HCFA's Division of Alternative Reimbursement states:

> The results infer that there is a difference in some of the characteristics of patients in a hospital and non-hospital setting. All such differences were in the hospitals' favor and were such that it would be reasonable to expect that these differences would cause hospitals to incur additional costs.[116]

For example, the memorandum showed the number of inpatient days of care was about 20 percent higher for patients serviced by hospital-based units than those treated in independent facilities in 1979.[117] Confronted with a conflict between the 1980 HCFA memo-

[114] Ibid.
[115] 47 Federal Register 6564.
[116] Hearings, p. 182.
[117] Hearings, p. 184.

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randum suggesting that hospitals might treat sicker patients and HCFA's statement in its reimbursement proposal that it had no evidence of such a possibility, the subcommittee asked HCFA's Office of Research, Demonstrations, and Statistics (ORDS) to explore the hospital case mix issue more extensively. The ORDS study [118] prepared in response to that request reaffirmed the general thrust of the 1980 memorandum, further calling into question HCFA's statement in its reimbursement proposal that it lacked evidence that hospitals might be burdened with a sicker, costlier patient population. Based on 1979 data, the study found that adjusting for age, sex, and race, patients served by hospital-based facilities were hospitalized 14 percent more days per 1,000 persons than those treated by independent units.[119] The study concluded:

> Thus the hospitalization experience of the two groups suggests that, in the aggregate, hospital-based facility patients may be "sicker" than their counterparts in freestanding facilities . . . [T]he fact that hospitalization rates are higher for hospital-based facility patients could be related to greater need levels and higher dialysis unit costs.[120]

Despite two HCFA studies—one in August 1980 and the other in February 1981—which concluded that hospital-based facility patients may be sicker than their independent facility counterparts, Dr. Carolyne K. Davis still contended that "we have no data to presume that the hospital does have a sicker mix of patients." [121]

In response to the controversy over hospital case mix generated by the subcommittee's investigation, Dr. Davis nonetheless announced during the subcommittee's hearings that HCFA had just undertaken a 60-day study to analyze the case mix issue in greater depth.[122] In a June 8, 1982, letter to the subcommittee accompanying the results of that study, Dr. Davis finally acknowledged the existence of "substantial evidence that hospital-based facilities have a more severe case-mix than freestanding facilities." [123] Adjusting for age, sex, and race, the study found that inpatient days of care per 1,000 persons in 1979 were 19 percent higher, average length of stay 11 percent higher, and discharges per 1,000 persons 7 percent higher for hospital-based than independent facility patients.[124] Age-adjusted survival rates were four percent lower for hospital-based than independent facility patients.[125]

The extent to which an apparently "more severe case mix" entitles hospitals to higher rates depends on HCFA's acquiring reliable baseline data relating dialysis costs to patient mix variations. Until HCFA obtains such data, it cannot intelligently assess, for rate-setting purposes, the meaning and significance of hospitals' substantially higher audited labor costs.

VII. Failure to Develop a Dual Reimbursement Rate

In Section 2145 of the Omnibus Budget Reconciliation Act of 1981, Congress mandated that the Secretary establish separate rates for hospital-based and independent dialysis facilities which reflect "the relative costs of providing services in such settings."

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[118] "Short Stay Hospital Utilization for ESRD Beneficiaries in Freestanding and Hospital-Based Facilities," Hearings, page 187.
[119] Hearings, p. 189.
[120] Hearings, p. 196.
[121] Hearings, p. 191.
[122] Ibid.
[123] Letter on file in subcommittee office.
[124] Study on file in subcommittee office.
[125] Ibid.

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The dual rates which HCFA has proposed for the two classes of renal facilities, however, are not based on the specific costs HCFA calculated for the two settings. In meeting Congress' dual rate requirement, HCFA proposes reimbursing hospital-based facilities an average rate $4 higher than independent facilities. In part, this $4 differential reflects an allowance for the supposedly higher overhead costs of hospitals. It also reflects HCFA's decision to set hospital-based facility rates at 105 percent of the cost median at which it proposes setting independent facility rates. While HCFA does not pretend that this 105 percent figure derives from the relative costs of each type of facility, it claims that the higher percentage compensates for factors such as the age of its hospital data.[126] In a November 1981 decision memorandum to Secretary Schweiker, HCFA Administrator Carolyne K. Davis conceded that "[t]he data for the independents is old (average age is late 1978) and no specific adjustment is provided" and that there is "no basis for allowing hospitals a 5 percent increase and adding nothing for independents."[127] Dr. Davis essentially acknowledged in this memorandum that the 105 percent adjustment is arbitrary; it is not "logically grounded in hospital cost or charge differences."[128] Dr. Davis testified that HCFA could just as easily set hospital rates at "110 percent, 115 percent, or 120 percent of the median," rather than at 105 percent.[129]

It is the committee's view that the age of HCFA's hospital data cannot constitute a justifiable basis for allowing hospitals higher rates than independent dialysis facilities, since the data for independent facilities are equally old and no such adjustment has been proposed for independent facilities.

In addition, the committee does not believe that an arbitrary differentiation between hospital-based and independent facility rates meets the Congressional requirement of a dual rate which reflects "the relative cost of providing services in such settings." In this connection, Larry K. Simmons, acting associate director of OIG's Office of Auditing, testified that HCFA has actually established a single rate with an "arbitrary" adjustment for hospitals rather than "two separately computed rates, one separately reflecting the hospital costs and the home component and another rate reflecting the independent cost and the home component."[130]

In developing a single base rate, HCFA used a methodology which combined its hospital-based and independent facility audit data. In deriving the $128 average per treatment rate for independent facilities, HCFA merged independent facility cost data with hospital cost data, and then set the rate for independent facilities at the median audited cost of hospital-based as well as independent facilities. Since the median audited cost for hospital-based facilities of $135 per treatment was $27 higher than the $108 per treatment median calculated for independent facilities, this procedure produced appreciably higher rates for independent facilities than their own cost experience might justify. Since the central purpose of the new rates is to bring payments more closely into line with actual costs, and to prevent unnecessary Federal expenditures, the procedure of computing an independent facility rate that includes hospital costs is highly questionable.

[126] Hearings, p. 210.
[127] Hearings, p. 200.
[128] Ibid.
[129] Hearings, p. 209.
[130] Hearings, pp. 151, 152.

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In the course of its investigation, the subcommittee discovered that HCFA had earlier rejected the inclusion of hospital cost data in its computation of independent facility rates on the grounds that it would appear to provide a substantial windfall for many lower cost facilities. On page 41 of the initial reimbursement rate proposal, which it circulated for internal review in June 1981, HCFA stated:

> One alternative, of course, would be to set the single rate based on the median costs of both independent and hospital-based facilities, which would be significantly higher than the median for independents alone. However, we do not believe this to be appropriate, because it would appear to provide a *substantial windfall* to those facilities—whether independent or hospital-based—that have demonstrated that they can furnish dialysis services at a much lower cost.[131] (Emphasis added.)

In testimony before the subcommittee, HCFA Administrator Carolyne K. Davis dismissed this statement as "an opinion that was expressed by some staff within the agency." [132] It was, however, part of a 113-page draft Federal Register Notice of Proposed Rulemaking which reflected the agency's position on ESRD facility rate setting prior to the August 1981 enactment of the Omnibus Budget Reconciliation Act.

In its February 12, 1982, proposal, HCFA candidly states: "A payment level less than the median might be justified because the median selected, which includes both hospital-based and independent facilities, is significantly higher than the median for independent facilities alone." [133] If, as Dr. Davis testified, hospitals are often considerably less efficient than independent dialysis units,[134] the decision to include hospital costs in arriving at independent facility reimbursement rates would appear to be indefensible. Since the objective of the new incentive rates is to encourage efficiency and minimize unnecessary Federal expenditures, the committee does not believe it good policy to base independent facility rates on cost data which, as HCFA acknowledges, could reflect inefficiencies in the operation of hospital-based dialysis units.

In view of HCFA's previously discussed failure to ascertain the actual cost of providing dialysis services, the committee wishes to emphasize that it is not passing judgment on the reasonableness of the dollar amounts independent facilities would receive under HCFA's incentive rate proposal. Rather, it questions whether HCFA's rate-setting procedures meet Congressional intent and are sound. The committee, in fact, recognizes that the $128 average independent facility rate which HCFA proposes is $10 less than the current average independent facility rate. Judging whether the proposed independent facility rates are reasonable also depends on determining what level of profit is fair and will assure sufficient availability of dialysis services, issues which HCFA has not addressed. In this connection, Dr. Davis acknowledged that HCFA has "not . . . made a judgment that relates to what constitutes a reasonable profit." [135]

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[131] Hearings, pp. 179, 180.
[132] Hearings, p. 180.
[133] 47 Federal Register 6565.
[134] Hearings, pp. 166, 181.
[135] Hearings, p. 216.

The decision to set a single base rate by merging independent and hospital-based facility cost data also lowers hospital-based facility rates. Despite the arbitrary percentage adjustment which HCFA has proposed making in this single rate for hospital reimbursement levels, hospital-based facilities would still receive an average of $3 per treatment less than their audited median cost of $135 per treatment. It appears both inconsistent and inequitable for HCFA to propose paying hospitals an average of $3 below their median audited costs, while setting rates for independent facilities substantially above their comparable costs. Assuming the validity of HCFA's hospital cost data, the agency's rate setting procedures appear to penalize hospital-based facilities, as Inspector General Kusserow has testified:

> Based on available cost data, Mr. Chairman, we believe that the proposed rates would on the one hand unfairly penalize the hospitals by not giving sufficient recognition to the costs that HCFA collected in their audits of the sample of hospitals.[136]

At the same time, the committee recognizes the widely held opinion that a more restrictive hospital reimbursement policy will force needed and achievable efficiencies in hospitals' management. While the committee questions HCFA's procedures for setting hospital-based facility rates, it reserves judgment on the adequacy of any given set of rates until HCFA has produced reliable hospital-based facility cost data.

[136] Hearings, p. 151.

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ADDITIONAL VIEWS OF HON. RAYMOND J. McGRATH

While I support the report of the Committee on the Management of End Stage Renal Disease Program, I wish to make some specific concerns I have known through the submission of these additional views.

The testimony presented to the Subcommittee by the Inspector General of the Department of Health and Human Services and members of his staff indicated that very substantial sums of Medicare funds have been misused by providers of dialysis treatment under the End Stage Renal Disease Program. They based those findings on incomplete audits of four dialysis facilities. The only response for the record to the audits is a letter from the director of the National Nephrology Foundation.

The job of investigating waste, fraud, and abuse in the Department of Health and Human Services is extremely difficult. The complexities of the Medicare accounting system and the profusion of regulatory requirements imposed on providers increase the problems for auditors. At the same time, it is imperative that Congress and the Administration have accurate and complete audit information in a timely manner. Many unanswered questions have been raised about the preliminary audit findings of the Inspector General.

Just as the Health Care Financing Administration lacks up-to-date cost information for the formulation of new treatment rate formulas, the Office of Inspector General has left a serious void in the information available to make needed changes in the ESRD program by failing to complete the audits of the facilities discussed during the Subcommittee hearings. If differences of opinion exist between the providers and the Office of Inspector General, then perhaps they should be aired and thoroughly investigated. If the I.G. does not have sufficient resources to conduct needed audits, then we should be looking for methods of improving his audit capabilities either through more funding or by delegating intermediaries or some other party with the responsibility of conducting program and financial audits.

The ESRD program is unique in the federal government's wide range of health care efforts. It is my hope that the many failures in administration of the program can be corrected. Without immediate action by HCFA, the Office of Inspector General, and other involved agencies, the ESRD program will remain an example of the federal government's inability to effectively manage and deliver health care. This jeopardizes any further attempts to expand protection of the public from the financial drain and other costs of catastrophic illness. Furthermore, continued disputes centering on the ESRD program will create uncertainties and anxiety among recipients of this life saving treatment.

RAYMOND MCGRATH.

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